Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 26, 2016	2016_449619_0022	005646-15, 026913-15, 011698-16	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Tullamore Care Community
133 KENNEDY ROAD SOUTH BRAMPTON ON L6W 3G3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMANTHA DIPIERO (619)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 7, 8, 11,12,13,14, 2016.

The following complaint inspections were completed: #005645-15 related to fall prevention, #011698-16 related to nutrition and hydration, the prevention of abuse and neglect, skin and wound care, and continence care and bowel management, and #026913-15 related to nutrition and hydration, residents' rights, skin and wound care, and medication.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Interim Director of Care (Interim DOC), Assistant Director of Care (ADOC), Behavioural Support Ontario (BSO) Nurse, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Medical Ethicist, Physiotherapist, Registered Dietitian, and family members. Inspector also toured the home, observed the provision of care, and reviewed the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to ensure that the resident was not neglected by staff.

Resident #002 was admitted to the home in September 2015. On admission, registered

staff #107 failed to reconcile the resident's medication orders correctly causing the resident to not receive a required daily medication for seven days.

On admission in September 2015, the resident received a nutrition and hydration assessment by the Registered Dietitian in the home who assessed that the resident regularly ate 75-100% of all daily meals. A review of the resident's meal tracking sheet indicated that the on six dates, the resident only ate 0-25% of the breakfast and dinner. RN #111 indicated that no interventions were implemented to address the resident's low food intake during their stay. Documentation from an interdisciplinary care conference held indicated that no referral was received in relation to inadequate nutritional intake.

The same interdisciplinary care conference summary noted that the resident had an emerging issue related to the condition of their skin; however, no skin and wound assessment was completed in relation to this finding and no documentation of the area in the resident's electronic health records was identified. On the day of the resident's planned discharge from the home to their private residence PSW #109 alerted RN #104 to a change in the resident's skin condition, citing that they had reported this to registered staff two days prior. A record review indicated that RN #104 instructed PSW #109 to treat and cover the area. A review of the home's policy titled "Skin and Wound Care Management Protocol", policy #VII-G-10.8, last updated April 2016, stated that "with a resident exhibiting altered skin integrity registered staff, including skin breakdown, pressure ulcers, skin tears or wounds, conduct a skin assessment". An interview with the family indicated that they were unaware of the skin and wound issue for the resident and were made aware of it by hospital staff after the resident's discharge from the home. In an interview, RN #104 stated that they were aware of the change in the resident's skin condition and that no action was taken as the "resident was leaving", and confirmed that they did not notify the resident's family of the change in the resident's condition.

During the resident's stay, resident #002 complained of pain for which they received a medication intervention. An interview with the ADOC confirmed that staff should have completed assessments on the resident to determine the cause of the pain. On the day of the resident's planned discharge resident #002's family found the resident to be in a state of confusion. Progress notes reviewed indicate that RN #104 informed the family the resident was fine; the family requested transfer to hospital. Interview with the interim DOC also confirmed that an incorrect medication administration record (MAR) was supplied to the responding paramedics. A review of the progress notes indicated that RN #104 did not enter any values for the resident's vital signs allegedly taken on the morning of the resident's discharge until three days later; as per an interview with the interim

DOC, the resident's vital signs were only entered by RN #104 after multiple requests by the home's administration.

An interview with the acting DOC confirmed that there was a pattern of the resident not receiving the care they required in relation to the monitoring of an area with altered skin integrity, medication reconciliation and administration, and the ongoing monitoring and assessments of the resident's health status. The interim DOC confirmed that as a result of these inactions the resident had a significant negative health outcome and required hospitalization and treatment. The Interim DOC confirmed that the staff failed to provide the resident with treatment and care required for their health and well-being which jeopardized the resident's health.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

On admission resident #002 was identified as a high nutritional risk. A review of the "Initial Nutritional Assessment" completed in September 2015, indicated that the resident required an identified number of servings of fluid per day. A review of the resident's fluid intake record indicated that the resident did not meet their daily fluid requirement for

seven consecutive days. A review of the home's policy titled “Dietitian Referral”, policy #XI-G-20.90, last revised January 2015, stated that “the Registered Dietitian will be informed of any health status changes of a resident that impacts nutrition”. Interview with Registered Dietitian #106 indicated that no referral was received by dietary staff in relation to resident #002’s poor fluid intake and stated that when a resident does not meet their fluid intake goals for three consecutive days or if there is a significant change in the resident health status, a dietary referral should be made for further assessment and intervention. Interview with interim DOC confirmed that the resident did not meet their fluid intake requirements and that staff failed to follow the dietary referral policy.

2. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy, or system instituted or otherwise out in place was complied with.

Resident #002 received an initial nutritional assessment on admission to the home in September 2015, and was identified as a nutritional risk. Interview with PSW #113 indicated that PSW staff were responsible for tracking fluid servings for residents and reporting low fluid intake to the registered staff. Interview with registered staff #111 indicated that on an identified date in September 2015, a three day look back was completed in relation to the resident’s poor fluid intake and confirmed that no referral to the home's Registered Dietitian was made. A review of the home's policy titled “Dietician Referral”, policy #XI-G_20.90, last revised January 2015, stated that “the Registered Dietician will be informed of any health status changes of a resident that impacts nutrition”. Interview with Registered Dietitian #106 indicated that the policy required the resident to be referred to the Registered Dietitian for further assessment and intervention. The Registered Dietitian confirmed that the resident should have been referred to them after not meeting their fluid intake for three consecutive days and indicated that the resident was at a high risk for dehydration. Interview with the interim Director of Care (DOC) confirmed that staff did not intervene when the resident was not meeting their daily food and fluid requirements and the home's policy for referral to the Registered Dietitian was not adhered to.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

Resident #002 experienced a decline in their health status. On an identified date in September 2015, the resident experienced a significant decline and was discharged to hospital at the request of family members. A review of the resident's written plan of care dated September 2015, indicated that resident #002 required blood pressure monitoring while taking prescribed medication. A review of the resident's health records indicated that no vital sign entries were entered by registered staff for a period of five days. Interview with interim DOC confirmed that registered staff should have documented their findings in the vital signs section of the resident's electronic health record after every vital signs check and that this was not completed.

A review of the internal investigation notes indicated that RN #104 claimed they took the resident's vital signs on the day of the resident's planned discharge and that the vital signs were "normal". The interim DOC confirmed that RN #104 failed to document their findings documented the vital signs three days after resident #002 was discharged at the request of the interim DOC. A review of the home's policy titled "Documentation – Resident Record", policy # VII-J-10.00, revised January 2015, stated that "interdisciplinary team members will document ongoing progress notes, and enter

ongoing weights and vital signs and respond to any variances".

2. The licensee failed to ensure that the resident was re-assessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #003 suffered a fall on an identified date in April 2015, was transferred to hospital for treatment. The following day the resident fell attempting to self-transfer. A review of the resident's personal health record indicated that the resident had a history of falls. A review of the progress notes indicated that the family requested a falls intervention tool be placed at the resident's bed side as part of the falls prevention strategy which was implemented in April 2015, after the resident was injured. Interview with PSW #109 indicated that they were aware the resident was at risk for falls; however, was unsure when new intervention were implemented. Interview with registered staff #108 indicated that staff were aware of the resident's requirement for a falls injury prevention device and confirmed that the device was put in place in April 2015, but that the use of the device as part of the resident's falls prevention strategy was not updated in the written plan of care until an identified date in August 2015. Interview with ADOC confirmed that the resident's plan of care was not revised to include the use of this device when the resident's care needs changed.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 6(9)(1) where the licensee shall ensure that the provision of care is set out in the plan of care is documented and with s. 6(10)(b) where the licensee shall ensure that the resident is re-assessed and the plan of care reviewed and reviewed when the resident's care needs change or care set out in the plan of care is no longer necessary., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Resident #002 was admitted to the home in September 2015. The home's physician ordered the resident's required medications as noted in the resident's medication administration record (MAR). On admission the resident's substitute decision maker (SDM) was made aware that some of the resident's prescription medications were not covered under the Ontario Drug Benefit program and to mitigate the cost of the drugs provided the home with the remainder of the resident's ordered medication in an unopened, labeled blister pack. As per the family interview, the resident required medication to manage a chronic condition. An interview with the interim DOC confirmed that registered staff #107 received the medication package from the family but failed to reconcile the medication order citing a knowledge deficit, and failed to report the need for medication reconciliation to the oncoming day shift charge nurse.

A review of resident #002's new admission medication order form included all the required medication for the resident; however, a review of the "Physician's Digiorder" did not include the medication that the registered staff failed to reconcile. A review of the home's policy titled "Medication Reconciliation" policy #VIII-F-10.40, revised January 2015, stated "medication reconciliation will be completed within 24 hours for any resident admission". An interview with the ADOC confirmed that that the identified medication should have been included in the resident's medication orders. The interim DOC confirmed that the resident required the medication twice daily and that they did not receive their prescribed medication for a period of nine days and confirmed that the staff did not administer medication to resident #002 in accordance with the directions specified by the prescriber.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 131. (2) where the licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #002 was admitted to the home in September 2015, and was noted to have a low risk for skin break down. On an identified date in September 2015, it was noted in the progress notes during an interdisciplinary care conference by RPN #112 that resident

#002 was exhibiting a change in the condition of their skin, and that no formal skin or wound assessment was completed. On a second identified date in September 2015, the change in the skin condition was noted by PSW #109 and that the PSW notified registered staff of the change in the resident's skin. A review of the progress notes and internal investigation interview notes indicated that RN #104 instructed the PSW #109 to tend to the identified area, but failed to complete a formal skin assessment. A review of the home's policy titled "Skin & Wound Care Management Protocol", policy # VII-G-10.80, last revised April 2016, stated that "with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, registered staff will conduct a skin assessment". Interview with Interim DOC confirmed that RN #104 should have completed a formal skin assessment on the resident as per the home's policy, with the use of a clinically appropriate assessment tool that was specifically designed for skin and wound assessment. [s. 50. (2) (b)

2. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

Resident #001 was discharged to hospital on an identified date in June 2015, with no issues related to their skin condition present. A review of the resident's progress notes and assessments indicated that on the resident's re-admission to the home in July 2015, the resident returned with altered skin integrity obtained during the resident's admission to hospital. The home's policy titled "Skin and Wound Care Management Protocol" policy #VII-G-10.80, last revised April 2016, stated "with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the registered staff will conduct a skin assessment…and initiate electronic weekly skin assessment". Interview with PSW staff #114 indicated that the resident returned from hospital with altered skin integrity. Interview with registered staff #111 indicated that registered staff were responsible for completing a head to toe skin assessment on a resident when they were newly admitted or re-admitted to the home, or when there was a change in skin condition until the issue was resolved. Registered staff #111 indicated that weekly skin assessments were not completed consistently and that some skin and wound notes were entered as progress notes. A review of the resident's health records indicated that the resident failed to receive a total of seventeen skin and wound assessment from the registered staff from September 2015, to May, 2016. An interview with the interim DOC confirmed that when a resident had specified altered skin integrity, the registered staff must complete a weekly skin assessment on the resident's wounds until the wounds

were resolved. The Interim DOC confirmed that the resident did not consistently receive a skin and wound assessment with the use of a clinically appropriate assessment tool.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 50. (2) where every licensee of a long-term care home shall ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

In September 2015, resident #001 was being prepared for transfer and discharge. At the time resident #001 was being discharged, two other residents were also being transferred to hospital. A review of the internal investigation notes indicated that an incorrect electronic medication administration record (EMAR) was provided to paramedics. The ADOC confirmed that an EMAR for resident #004 was given to paramedics in error by registered staff #104 and subsequently to hospital staff instead of the correct EMAR for resident #001. The interim DOC confirmed that resident #004's personal health information was not protected and that their right to privacy was violated.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #002 was admitted to the home in September 2015. A review of the resident's written plan of care last revised September 2015, indicated that the resident required daily vital signs monitoring in relation to medication that the resident required. A review of the resident's health record indicated vital signs were not recorded for a period of five days. A review of the home's policy titled, "Documentation – Resident Record" policy # VII-J-10.00, last revised January 2015, stated, "Document ongoing progress notes and enter ongoing weights and vital signs and respond to any variances". An interview with the interim DOC confirmed that the registered staff failed to document the ongoing vital signs measurements for resident #002 and that the home's policy on documentation was not adhered to by registered staff.

Issued on this 28th day of September, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMANTHA DIPIERO (619)
Inspection No. / No de l'inspection :	2016_449619_0022
Log No. / Registre no:	005646-15, 026913-15, 011698-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 26, 2016
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Tullamore Care Community 133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Astrida Kalnins

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare and submit a plan of corrective action that shall:
a. Ensure that residents are not neglected by staff when there is a change in the resident's medical condition.
b. Ensure that all residents who experience a change in condition are assessed for changes using a clinically appropriate assessment tool.
c.The licensee shall prepare and submit a plan that includes training for the assessments of residents, medication reconciliation, documentation of relevant information, following the plan of care, and notifying the Substitute Decision Maker where appropriate for all staff who provide direct care to residents.
d. Ensure that staff monitor and evaluate changes in condition and take appropriate actions for all short stay residents.
Prepare and submit the plan to Samantha.Dipiero@ontario.ca by October 31, 2016

Grounds / Motifs :

1. The licensee failed to ensure that the resident was not neglected by staff.

Resident #002 was admitted to the home in September 2015. On admission, registered staff #107 failed to reconcile the resident's medication orders correctly causing the resident to not receive a required daily medication for seven days.

On admission in September 2015, the resident received a nutrition and hydration assessment by the Registered Dietitian in the home who assessed that the resident regularly ate 75-100% of all daily meals. A review of the resident's meal tracking sheet indicated that the on six dates, the resident only ate 0-25% of the breakfast and dinner. RN #111 indicated that no interventions were implemented to address the resident's low food intake during their stay.

Documentation from an interdisciplinary care conference held indicated that no referral was received in relation to inadequate nutritional intake.

The same interdisciplinary care conference summary noted that the resident had an emerging issue related to the condition of their skin; however, no skin and wound assessment was completed in relation to this finding and no documentation of the area in the resident's electronic health records was identified. On the day of the resident's planned discharge from the home to their private residence PSW #109 alerted RN #104 to a change in the resident's skin condition, citing that they had reported this to registered staff two days prior. A record review indicated that RN #104 instructed PSW #109 to treat and cover the area. A review of the home's policy titled "Skin and Wound Care Management Protocol", policy #VII-G-10.8, last updated April 2016, stated that "with a resident exhibiting altered skin integrity registered staff, including skin breakdown, pressure ulcers, skin tears or wounds, conduct a skin assessment". An interview with the family indicated that they were unaware of the skin and wound issue for the resident and were made aware of it by hospital staff after the resident's discharge from the home. In an interview, RN #104 stated that they were aware of the change in the resident's skin condition and that no action was taken as the "resident was leaving", and confirmed that they did not notify the resident's family of the change in the resident's condition.

During the resident's stay, resident #002 complained of pain for which they received a medication intervention. An interview with the ADOC confirmed that staff should have completed assessments on the resident to determine the cause of the pain. On the day of the resident's planned discharge resident #002's family found the resident to be in a state of confusion. Progress notes reviewed indicate that RN #104 informed the family the resident was fine; the family requested transfer to hospital. Interview with the interim DOC also confirmed that an incorrect medication administration record (MAR) was supplied to the responding paramedics. A review of the progress notes indicated that RN #104 did not enter any values for the resident's vital signs allegedly taken on the morning of the resident's discharge until three days later; as per an interview with the interim DOC, the resident's vital signs were only entered by RN #104 after multiple requests by the home's administration.

An interview with the acting DOC confirmed that there was a pattern of the resident not receiving the care they required in relation to the monitoring of an area with altered skin integrity, medication reconciliation and administration, and

the ongoing monitoring and assessments of the resident's health status. The interim DOC confirmed that as a result of these inactions the resident had a significant negative health outcome and required hospitalization and treatment. The Interim DOC confirmed that the staff failed to provide the resident with treatment and care required for their health and well-being which jeopardized the resident's health. (619)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare and submit a plan of corrective action that shall ensure that staff complete ongoing nutrition and hydration assessments for all residents and refer to the registered dietician for interventions when the resident's goals are not met, including:
i. Providing education to all direct care staff on nutrition and hydration requirements, and referral process for assessment and intervention.
ii. Ensure that all staff follow the plan of care especially in relation to nutrition and hydration.

Prepare and submit the plan to Samantha.Dipiero@ontario.ca by October 31, 2016

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

On admission resident #002 was identified as a high nutritional risk. A review of the "Initial Nutritional Assessment" completed in September 2015, indicated that the resident required an identified number of servings of fluid per day. A review of the resident's fluid intake record indicated that the resident did not meet their daily fluid requirement for seven consecutive days. A review of the home's policy titled "Dietitian Referral", policy #XI-G-20.90, last revised January 2015, stated that "the Registered Dietitian will be informed of any health status changes of a

resident that impacts nutrition". Interview with Registered Dietitian #106 indicated that no referral was received by dietary staff in relation to resident #002's poor fluid intake and stated that when a resident does not meet their fluid intake goals for three consecutive days or if there is a significant change in the resident health status, a dietary referral should be made for further assessment and intervention. Interview with interim DOC confirmed that the resident did not meet their fluid intake requirements and that staff failed to follow the dietary referral policy.

2. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy, or system instituted or otherwise out in place was complied with.

Resident #002 received an initial nutritional assessment on admission to the home in September 2015, and was identified as a nutritional risk. Interview with PSW #113 indicated that PSW staff were responsible for tracking fluid servings for residents and reporting low fluid intake to the registered staff. Interview with registered staff #111 indicated that on an identified date in September 2015, a three day look back was completed in relation to the resident's poor fluid intake and confirmed that no referral to the home's Registered Dietitian was made. A review of the home's policy titled "Dietician Referral", policy #XI-G_20.90, last revised January 2015, stated that "the Registered Dietician will be informed of any health status changes of a resident that impacts nutrition". Interview with Registered Dietitian #106 indicated that the policy required the resident to be referred to the Registered Dietitian for further assessment and intervention. The Registered Dietitian confirmed that the resident should have been referred to them after not meeting their fluid intake for three consecutive days and indicated that the resident was at a high risk for dehydration. Interview with the interim Director of Care (DOC) confirmed that staff did not intervene when the resident was not meeting their daily food and fluid requirements and the home's policy for referral to the Registered Dietitian was not adhered to. (619)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Samantha Dipiero

Service Area Office /
Bureau régional de services : Hamilton Service Area Office